KANSAS MEDICAL SOCIETY
Established 1859

To: House Health and Human Services

From: Rachelle Colombo
Executive Director

Date: February 17, 2021

Re: SB 174, allowing APRNs to practice without supervision

The Kansas Medical Society appreciates the opportunity to testify in opposition to SB 174, allowing an Advanced Practice Registered Nurse (APRN) to independently engage in the practice of medicine. The bill eliminates the requirement for physician supervision and authorizes APRNs to independently diagnose, prescribe, treat, order diagnostic tests and supervise other health care providers without limitation. These privileges are defined in statute as the practice of medicine and have been restricted to those with medical education and training or are granted in conjunction with formal supervision/collaboration.

By removing the requirement for physician supervision/collaboration and expanding their scope of practice, the bill grants nurses a scope of practice which is without any statutory limitations, and equivalent to that of aa physician, despite the APRN not having medical education and training. Finally, under SB 174, APRNs would be licensed and regulated by the board of nursing, despite the clear overlap into the practice of medicine and surgery. This is inconsistent with all other health care providers. SB 174 creates two different standards for the practice of medicine and patient care – one for physicians, and another for APRNs, though the law would allow them to practice interchangeably. The Kansas Medical Society opposes allowing those without adequate training to practice medicine without limitation, supervision, or appropriate regulation.

The healing arts act outlines independent medical diagnosis and prescription as the sole purview of medical doctors (MD) and doctors of osteopathy (DO). Further, the practice of medicine and surgery, which is statutorily limited to MDs and DOs, is outlined in KSA 65-2869 as: "*persons who prescribe, recommend or furnish medicine or drugs, or perform any surgical operation of whatever nature by the use of any surgical instrument, procedure, equipment or mechanical device for the diagnosis, cure or relief of any wounds, fractures, bodily injury, infirmity, disease, physical or mental illness or psychological disorder of human beings.*"

The practice of medicine is intentionally limited to those who have completed medical school and residency and are licensed and regulated by a board with members who also have medical education and training - the Board of Healing Arts.

Physicians can delegate specific medical acts to those they supervise directly or indirectly, but they are responsible for the care provided under delegated authority. Proponents argue that this supervision is unnecessary, cumbersome and costly and that they do not wish to practice medicine, only nursing. But, the delegated acts they currently perform are the practice of medicine which is why they require physician supervision. If the requirement for physician supervision is eliminated, their statutory scope should not include the privileges outlined in SB 174. Rather, they should be limited to the practice of nursing, which does not include diagnosis, initiation of treatment, or unlimited prescribing.

Proponents of SB 174 also argue that the requirement for physician supervision is a barrier to practice that presents access to care hurdles in rural areas that their bill would solve. But, data from the Kansas Board of Nursing shows that the number of APRNs licensed in Kansas has grown by 300% in the last decade. In fact, Kansas ranks 3rd in the nation for the ratio of APRNs to patients per capita. Additionally, states that have granted scope expansions and relaxed supervision requirements have not realized a growth in the number of APRNs practicing in rural areas. (See attached).

Proponents claim more than twenty states allow "full practice authority for APRNs". But in fact, only three states in the nation allow APRNs to practice without a collaborative practice agreement or some limitations on scope of practice. In fact, in many states where APRNs practice without supervision, they have a much narrower scope with more limitations on prescribing and procedures than what Kansas APRNs are currently allowed.

To ensure that Kansans in both rural and urban parts of the state have access to the same quality of care, providers must be licensed and regulated consistently and commensurate with their education and training. Providers independently practicing medicine ought to be held to the same standards as physicians. Alternately, independent practitioners not educated, trained and regulated as physicians, should not be allowed to practice medicine and surgery without appropriate oversight or collaboration. Though this perennial proposal is often reduced to being codification of current nursing practice, or necessary for more patient access – neither is true. SB 174 represents a significant change in patient protection and the regulation of the practice of medicine. KMS respectfully requests your opposition to the passage of SB 174.

Issue brief: Access to care

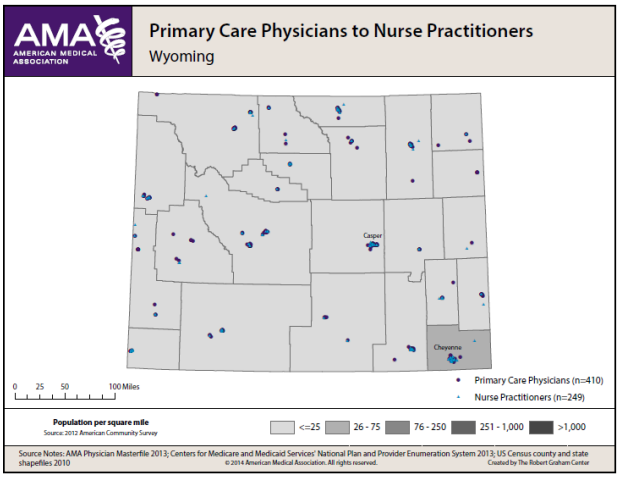
Proponents of scope expansions often claim such measures are necessary to expand access to care in rural areas. However, in reviewing the actual practice locations of primary care physicians compared to nurse practitioners, it is clear, that physicians and nurse practitioners tend to practice in the same areas of the state - even in those states where nurse practitioners can practice without physician supervision or collaboration. For the most part, state laws that have expanded the scope of practice of nurse practitioners have not necessarily led to more nurse practitioners in rural areas.

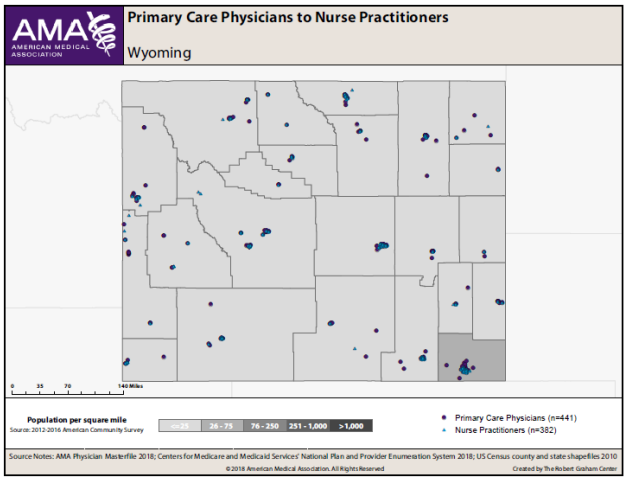
The AMA has mapped the actual practice locations of primary care physicians and nurse practitioners in all-50 states, DC and nationwide using data from the AMA Masterfile to determine the practice location of primary care physicians and data from the Centers for Medicare and Medicaid Services (CMS) for the location of nurse practitioners. Following are maps from 2013 and 2018 illustrating the practice location of nurse practitioners and primary care physicians from states with varying levels of nurse practitioner independent practice.

Independent Practice States

Wyoming

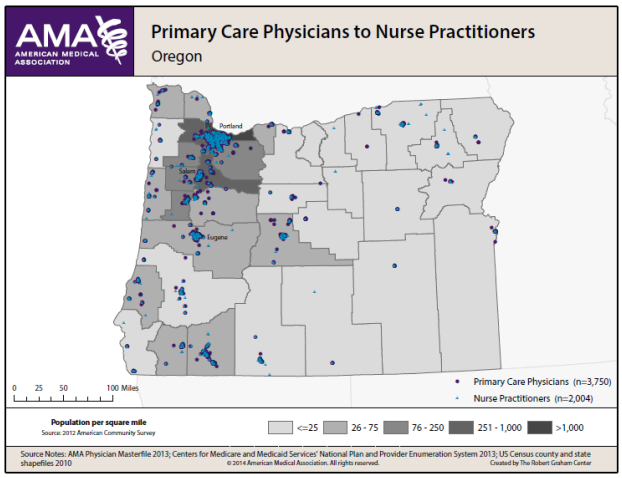
In 2018 there were only 382 nurse practitioners in Wyoming compared to 441 Primary Care Physicians. The number of nurse practitioners in the state has not increased since they allowed independent practice, nor have nurse practitioner moved into rural areas of the state.

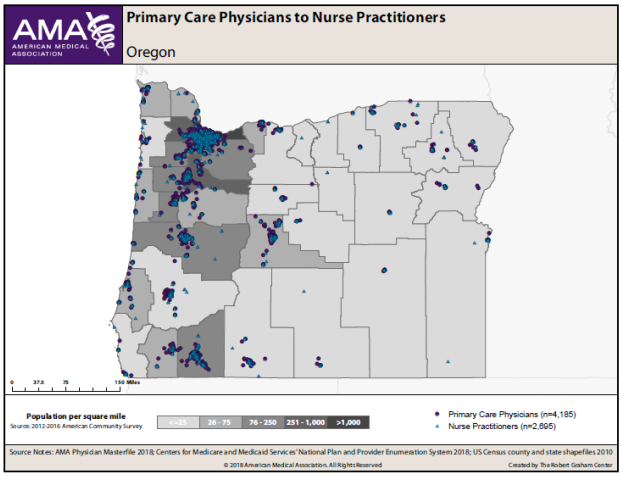




Oregon

Similar to Wyoming, while allowing independent practice for decades, nurse practitioners have not moved to rural areas of the state and continue to practice in the same areas of the state as physicians. The number of nurse practitioners in the state increased from 2,004 in 2013 to 2,695 in 2018 a slower rate of growth than other areas of the country.

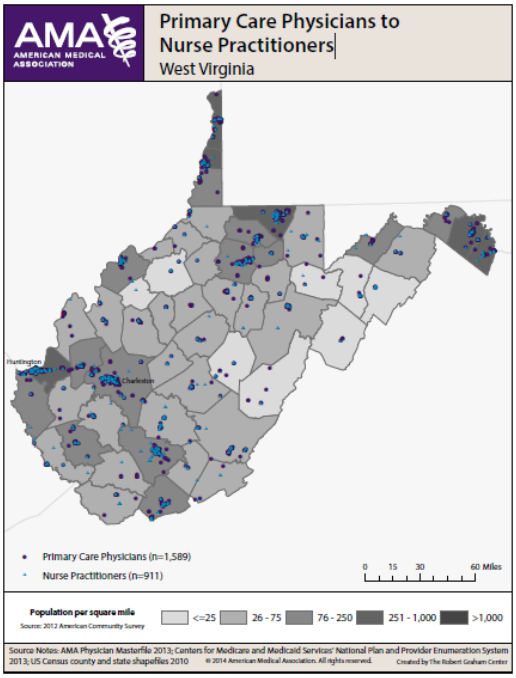


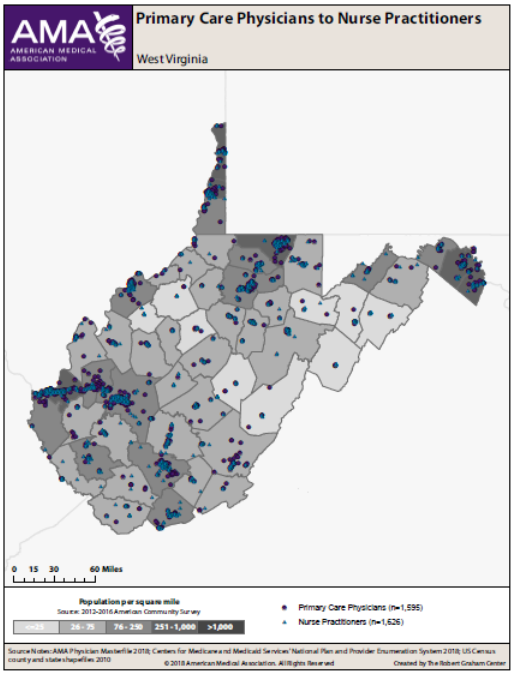


Physician involvement required for 3 years to prescribe

West Virginia

West Virginia enacted legislation in 2017 that allows nurse practitioners to diagnose and treat patients without physician involvement; they are still required to have a collaborative relationship for prescriptive practice with a physician for three years. While there was an increase in the overall number of nurse practitioner in the state, they continued to practice in the same areas of the state as physicians.

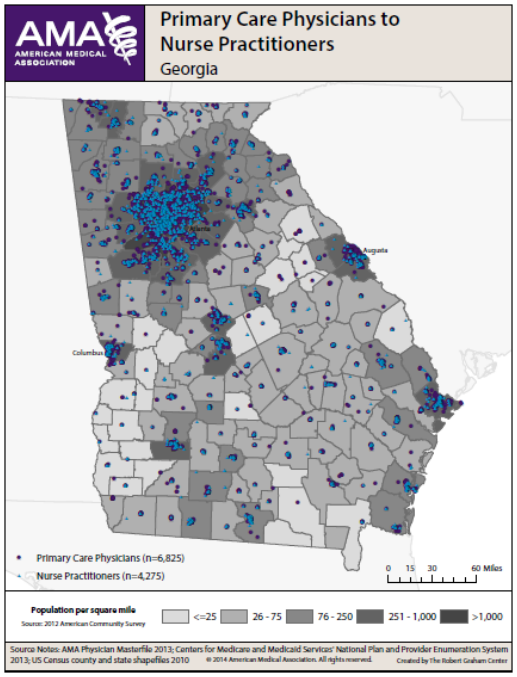


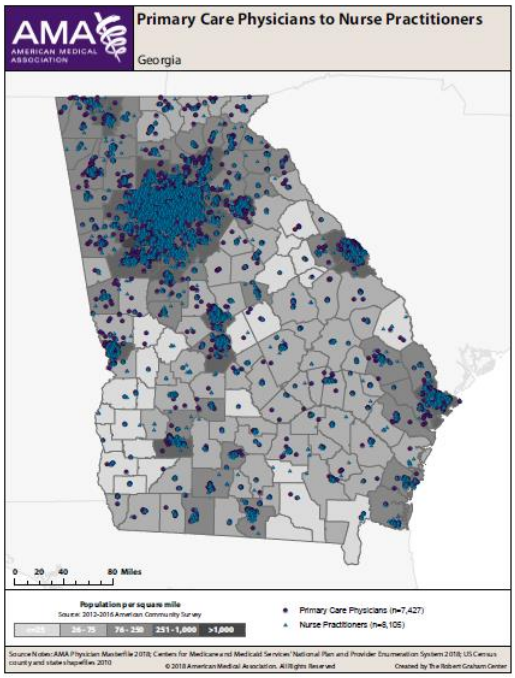


Physician supervision or collaboration required to diagnose, treat, and prescribe

Georgia

In Georgia, nurse practitioners practice pursuant to a protocol agreement with physician supervision and delegation. Supporting a physician-led team-based care approach, Georgia has seen tremendous growth in the number of nurse practitioners in the state, increasing from 4,275 in 2013 to 8,105 in 2018. This demonstrates that changes in nurse practitioner scope of practice laws are not the sole reason for growth of nurse practitioners in a state.





Other studies confirm our findings

The Graduate Nurse Demonstration Project which was mandated as part of the Affordable Care Act of 2010, involved the Centers for Medicare & Medicaid Services (CMS) providing payments to five eligible hospitals, each of which partnered with schools of nursing (SONs), community-based care settings (CCSs), and other hospitals to expand clinical education for additional APRN students.[1] One of the goals of the project was to determine if funding clinical APRN education would increase the number of APRNs and to determine the employment choices of APRNs following graduation. A study of alumni from this program found only 25% of alumni served medically underserved communities, however, the vast majority were in urban settings, as only 9% went on to work in rural areas and only 2% worked in FQHCs.[2]

[1] The Graduate Nurse Education Demonstration Project: Final Evaluation Report, Centers for Medicare and Medicaid Services. August 2019. https://innovation.cms.gov/files/reports/gne-final-eval-rpt.pdf. Accessed Oct. 9, 2020

[2] *Id.*

Fewer nurse practitioners are providing primary care

These maps likely overrepresent the number of nurse practitioners practicing in primary care. While the maps compare primary care physicians to all nurse practitioners in a state, data have shown a growing number of nurse practitioners are not practicing in primary care. For example, after examining state licensing renewal forms, the Oregon Center for Nursing found only 25% of nurse practitioners practice in primary care. This trend is also supported in recent workforce studies, which have found newly graduated nurse practitioners are more likely to enter specialty or subspecialty care rather than primary care.[3]

Physician-led team care is equitable care

The AMA is deeply concerned with the notion that patients in rural and underserved areas, often a vulnerable and medically complex population, should settle for care from a health care provider with a fraction of the education and clinical training of physicians. All patients, regardless of zip code, deserve care led by a physician. Rather than allow an unproven path forward, policymakers should consider proven solutions to increasing access to care, including supporting physician-led team-based care. **In fact, evidence shows that states that require physician-led team-based care have seen a greater overall increase in the number of nurse practitioners compared to states that allow independent practice.** Other proven reforms include telehealth expansion, expanding GME slots, loan forgiveness programs for physicians practicing in rural and underserved areas and programs that encourage students from underserved areas to pursue medical school.

NP scope expansion has led to RN workforce shortage

Nurse practitioners have used the notion of a physician shortage to advance their scope of practice, however, one often unmentioned result of the growth of the NP workforce, is its impact on the registered nurse (RN) workforce in the country. According to an analysis of the Bureau of Labor Statistics, between 2014 and 2024 an estimated one million new RNs will be needed across the country.[4] At this same time, however, the growth of the NPs workforce has reduced the size of the RN workforce by up to 80,000 nationwide.[5]

[3] Martiniano R, Wang S, Moore J. A Profile of New York State Nurse Practitioners, 2017. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; October 2017

[4] Health Care Employment Projections, 2014-2024: An Analysis of Bureau of Labor Statistics Projections by Setting and by Occupation, Center for Health Workforce Studies, School of Public Health, SUNY Albany; (2016).

[5] David I. Auerbach, Peter I. Buerhaus, and Douglas O. Staiger, "Implications of the Rapid Growth of the Nurse Practitioner Workforce in the US," Health Affairs; 39, 2 (Feb. 2020).